MENTAL HEALTH CONSULTANT REFERRAL
SUSPICION OF A DISABILITY

Name of Student		Date of Referral
SSN	DOB	Date of Entry
Last School Attended	Last Grade Attended	Last Year Attended
Referring Staff Person		Position

Is or was the student enrolled previously in ESL classes? (Circle one)	**Yes**	**No**
If yes, answer the following:		
What language is most spoken by the student?		
What language is most spoken in the home?		
Was English the student's first spoken language?		

Does the student have a history of special education services or accommodations? (Circle one)	**Yes**	**No**

If yes, list known types of services, accommodations, and/or available documentation:

Previous Services/Accommodations	Documentation Type (e.g., psychosocial, etc.)	Document Location (e.g., last high school, VR, attached, etc.)

Most Recent TABE Scores								
Reading Vocabulary	Reading Comp.	*Reading Total*	Math Comp.	Math Con. and App.	*Math Total*	Language Expression	Language Mechanics	*Language Total*

Reason for Referral:

List specific behaviors, observations, concerns, or sources of information that led you to suspect the presence of a disability?
What specific interventions and strategies have you employed to assist the student with any of the above areas of concern (i.e., student continues to struggle with reading – used direct instruction, phonics-based activities, accommodated with OCR/speech output devices in classroom, etc.)?
Other comments or concerns:

I understand that the confidentiality of this student's information is to be strictly observed and respected at all times in accordance with Job Corps confidentiality policies and regulations.

Referring Staff Person Date

Received by CDD Date

Disposition of Referral by CDD			
Submitted to CMHC for further review?	Yes	No	If yes, date submitted:
Disposition of Referral (e.g., explanation of decision to submit referral to CMHC or not):			

CDD Signature Date

Disposition of Referral by CMHC

CMHC Signature Date

Action Log*		
Action Taken	**Date**	**Contact Person/Comment**

*Log can be used to track actions taken in response to referral (i.e., contacted VR to determine eligibility for services, VR scheduled date for assessment testing, etc.).

This form and any supporting documentation are to be maintained in a secure location at all times. Discussion of this information should be restricted to those staff with a "need to know" (e.g., CDD, Dept. Manager, CMHC, and the trainee's Case Management Team). Store form and any existing documentation with the student's Personal Career Development Plan as long as the PCDP is stored or maintained in a secure environment or unless there is sensitive health information that must be maintained separately within the Wellness Center.

_____ Notified staff referrer of disposition of referral request.

CDD Initials Date